

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 18, 19, 20, 21, and 22, 2013</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Survey team: Lara Richards, RN, TC Brenda Buroker, RN Amber Bloss, Medical Surveyor William "Chris" Greeney, Medical Surveyor Janelyn Kulik, RN (2/22/13)</p> <p>Census bed type: SNF/NF: 92 Residential: 9 Total: 101</p> <p>Census payor type: Medicare: 16 Medicaid: 58 Other: 27 Total: 101</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after March 24, 2013</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on March 1, 2013, by Janelyn Kulik, RN.						

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F0272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were thoroughly assessed for the use of psychoactive drugs for 4 of 10 residents reviewed</p>			F0272	<p>F 272 Comprehensive Assessment</p> <p>It is the practice of this provider to</p>		03/24/2013

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	<p>for unnecessary medication use. (Residents #87, #61, #65, and #131)</p> <p>Findings include:</p> <p>1. Observation and interview of Resident #87 on 2/18/13 at 2:00 p.m., indicated the resident was alert to person, place and time. The resident responded appropriately to several questions and provided good insight to answers.</p> <p>The resident's record was reviewed on 2/20/13 at 11:00 a.m., and indicated the resident was admitted to the facility in July 2012, with the diagnoses including, but not limited to, dementia with behavioral disturbance, dementia with delusions, depression and anxiety. The Physician orders, indicated the resident received Risperdal (an anti-psychotic medication) 0.25 milligrams (mg) in the morning, Risperdal 0.25 mg in the evening and Lexapro (an antidepressant) 10 mg every day.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/1/12, indicated a Brief Interview for Mental Status (BIMS) of 13 of 15, indicating minimal cognitive deficit. The MDS indicated the resident had no</p>				<p>ensure that residents are thoroughly assessed for the use of psychoactive drugs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Residents #87, #61 and #65 have been thoroughly assessed for the use of psychoactive drugs. Resident #131 no longer resides in the facility. The consultant pharmacist reviewed Residents #87, #61, #65, and #130 medications to ensure that they are free from unnecessary drugs, making recommendations as needed. Residents #87, #61, #65, and #130 medication regimens are reviewed routinely for a gradual dose reduction as required per state regulation. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>		

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	<p>behavior or mood problems and received antipsychotic drugs and an antidepressant seven days a week.</p> <p>The 10/27/12 and 1/18/13, Quarterly MDS assessments, indicated a BIMS of 15 of 15 (no cognitive deficit) and no behavioral or mood problems. The resident continued to receive antipsychotic drugs and an antidepressant seven days a week.</p> <p>On 2/22/13 at 11:00 a.m., the Executive Director was informed of the concerns regarding the continued use of the psychoactive drugs and requested any additional information available.</p> <p>Interview on 2/22/13 at 11:30 a.m., the Director of Nursing was informed of the lack of a thorough assessment regarding the use of the psychoactive drugs and requested any additional information available.</p> <p>On 2/22/13 at 1:30 p.m., the Social Service Director provided behavior flow sheets which were blank as well as the Section D of the MDS for mood. No other information was provided to indicate the resident received a thorough assessment for the use of the psychoactive medications.</p>			<ul style="list-style-type: none"> · All residents who receive a psychoactive drug have the potential to be affected by the alleged deficient practice. · A consultant pharmacist reviews each resident's medication regimen routinely but no less than monthly to ensure that they are free from unnecessary drugs, making recommendations as needed. · Before any resident receives a new order for a psychoactive drug they will be thoroughly assessed by the physician for the use of the medication. · Social Services and the Interdisciplinary team will review psychoactive medication use within the first 5 days of admission to determine past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. · A comprehensive care plan will be created for assessment and tracking of the medication. · Social Services will audit the Gradual Dose Reduction tracker on a routine basis. · Social Services will review care plans for residents using psychoactive medication for continued indication for use and placement. · Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed 			

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				<p>and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met.</p> <ul style="list-style-type: none"> The Charge Nurse is responsible to follow-up on consultation orders as needed. The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The interdisciplinary team was re-educated on Psychotropic Medication use on 3/8/13 by the Social Service Consultant. The nurse staff was re-educated on Psychotropic medication use by March 24, 2013 by Social Services. Before any resident receives a new order for a psychoactive drug they 			

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					<p>will be thoroughly assessed by the physician for the use of the medication.</p> <ul style="list-style-type: none"> Social Services and the Interdisciplinary team will review psychoactive medication use within the first 5 days of admission to determine past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. A comprehensive care plan will be created for assessment and tracking of the medication. Social Services will audit the Gradual Dose Reduction tracker on a routine basis. Social Services will review care plans for residents using psychoactive medication for continued indication for use and placement. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met. The Charge Nurse is responsible to follow-up on consultation orders as needed. 		

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				<ul style="list-style-type: none"> The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. The Social Service Director or designee will ensure implementation or compliance by March 25, 2013. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tools titled "Psychoactive Management" and Behavior Management" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with privacy practices. The CQI committee reviews the audits monthly and 			

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	<p>2. The record for Resident #65 was reviewed on 2/20/13 at 10:51 a.m. The Significant change Minimum Data Set (MDS) assessment dated 1/16/13, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 3/15, indicating cognitive impairment. The MDS also indicated the resident had the psychiatric diagnoses of anxiety, depression, and psychotic disorder (other than schizophrenia).</p> <p>A Physician's order dated 11/12/12, indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered on an as-needed basis. A Physician's order dated 11/21/12, indicated the resident was to receive Seroquel (an anti-psychotic medication) 50 mg at bedtime and 25</p>			<p>action plans are developed as a threshold of 95% is not met to ensure continual compliance.</p> <p>The Director of Nursing Services and the Social Service Director or their designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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	<p>mg in the morning.</p> <p>Interview with the Social Services Director on 2/22/13 at 8:55 a.m., indicated the Ativan was used to treat anxiety and the Seroquel was an anti-depressant medication.</p> <p>Resident #65's February 2013 Medication Administration Record (MAR) listed diagnoses, which included, but were not limited to, Alzheimer's, Parkinson's, Depression, Adjustment Disorder, Worsening of Alzheimer's, Behaviors with Delusions, Insomnia, anxiety.</p> <p>Further interview with the Social Service Director indicated the facility had just began a new system in the past month in reassessing for the need of medications as behavioral interventions. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence that there had been ongoing reassessment of the resident's use of psychoactive medications.</p> <p>3. Observation on 2/18/13 at 12:20 p.m., during the lunch meal, staff were unable to get Resident #61 to open his eyes while sitting at the</p>						

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	<p>lunch table. The resident had been observed sitting with his eyes closed in the late morning prior to lunch while other residents were involved in activities. Observations on 2/19 at 11:00 a.m. and 2/20/13 at 2:45 p.m., found the resident in the dayroom sitting in a chair with his eyes closed.</p> <p>Review of Resident #61's record on 2/20/13 at 10:59 a.m., indicated a Quarterly Minimum Data Set (MDS) assessment dated 11/13/12. The MDS indicated the resident had the diagnoses of Alzheimer's dementia, depression, psychotic disorder other than schizophrenia. The staff assessment of mood section, indicated the resident had trouble falling asleep or sleeping too much.</p> <p>Review of the February 2013 Medication Administration Record (MAR), indicated the resident's diagnoses, included but were not limited to, Alzheimer's with tremors, hypertension, chronic constipation, meningioma, insomnia, dementia with agitation, and depression. The MAR, indicated the resident was receiving Melatonin (an herbal supplement for sleep) 5 milligrams (mg) daily at bedtime. Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated the Melatonin</p>						

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	<p>was used to treat insomnia.</p> <p>The resident's care plan updated on 1/31/13, indicated the following interventions for Insomnia; pain management, reposition, and encourage resident to be awake in day.</p> <p>Further interview with the Social Service Director, indicated the facility had just began a new system in the past month in reassessing for the need of medications. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence there had been ongoing reassessment of the resident's use of Melatonin. The Social Service Director indicated the resident "had no insomnia last month or this month." The Social Service Director indicated no meeting with the physician had yet occurred to reassess the resident's need for the medication.</p> <p>4. The record for Resident #131 was reviewed on 2/22/13 at 3:27 p.m. The Minimum Data Set (MDS) assessment dated 12/18/12, indicated the resident was diagnosed with "mild depression" with no behaviors and had a BIMS (Brief Interview for</p>						

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	<p>Mental Status) score of 13/15, indicating he was cognitively intact. Review of the February 2013 Physician orders summary (POS), indicated diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease, Ataxia, Bladder Cancer, Dementia, Altered Mental state, Falls, acute renal Failure, Epilepsy, Dementia with Delusions, Anxiety, Mild Encephalopathy and Insomnia. The POS indicated the resident was prescribed Trazadone (an anti-depressant) 50 milligrams (mg) 1 hour before bedtime, Namenda (a medication to treat Alzheimer's) 5 mg twice daily, Diazepam (an anti-anxiety medication) 5 mg twice daily, and Paroxetine (an antidepressant medication) 20 mg in the morning and 10 mg in the evening.</p> <p>A 2/15/13 Physician's progress note, indicated the resident had also been receiving Remeron (an anti-depressant) but it was discontinued because the resident "states that he feels too sedated (since starting Remeron)."</p> <p>Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for</p>						

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	<p>"the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. However, the January 2013 and February 2013 Behavior Tracking Flow Sheets, indicated those behaviors had not been exhibited since the care plan was initiated. There was no indication in the resident's record indicating an assessment had been completed to determine a need for the medications.</p> <p>Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated she would need to find out why the resident was on medications used to treat depression.</p> <p>3.1-31(a)</p>						

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F0278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to accurately assess a resident's dental status for 1 of 3 residents reviewed for dental care out of the 7 who met the criteria for dental services. (Resident #76)</p> <p>Findings include:</p>			F0278	<p>F278 Assessment Accuracy/Coordination/Certified</p> <p>It is the practice of this provider to accurately assess residents' dental status on the MDS.</p>		03/24/2013

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	<p>Interview with Resident #76's family on 2/19/13 at 1:04 p.m., indicated the resident was not getting her dentures soaked on a routine basis.</p> <p>On 2/21/13 at 8:44 a.m., record review indicated Resident #76's diagnoses, included, but were not limited to, arthritis, hypertension, osteoporosis, dementia, and depression. Review of the Initial MDS (Minimum Data Set) assessment dated 10/25/12, indicated the resident was assessed as having all her natural teeth.</p> <p>Interview with LPN #4 on 2/22/13 at 11:12 a.m., indicated she was unsure of the resident's dental status. The LPN located the resident's Admission note dated 10/19/12, which indicated the resident had upper and lower dentures.</p> <p>Interview with the MDS Coordinator on 2/22/13 at 1:36 p.m., indicated the resident did have upper and lower dentures. The MDS Coordinator indicated the resident had been incorrectly assessed as having her natural teeth on her Initial MDS assessment.</p> <p>3.1-31(c)(9)</p>				<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· Resident #76's MDS has been modified to reflect her dental status.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents have the potential to be affected by the alleged deficient practice.</p> <p>· All residents' MDSs were reviewed to ensure their correct dental status was reflected.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>· Dental status is reviewed on all</p>		

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					<p>admission, comprehensive, and significant change MDSs.</p> <ul style="list-style-type: none"> The MDS coordinator and assistant received re-education on reviewing dental status on the MDS by the Executive Director by March 24, 2013. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool "Assessments (Admission, Quarterly, Significant Change)" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with obtaining and documenting radiology results. The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education or 		

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				<p>disciplinary action.</p> <p>· The Director of Nursing Services or her designee is responsible to monitor for compliance.</p> <p>· Compliance Date: March 24, 2013</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to ensure a care plan related to depression was initiated for 2 of 10 residents reviewed for unnecessary medications. (Residents #65 and #131)</p> <p>Findings include:</p> <p>1. The record for Resident #65 was reviewed on 2/20/13 at 10:51 a.m. The Significant change Minimum Data Set (MDS) assessment dated 1/16/13, indicated the resident had a</p>			F0279	<p>F279 Comprehensive Care Plans</p> <p>It is the practice of this provider to ensure that a care plan related to depression is initiated when a resident has that diagnosis.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>		03/24/2013

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	<p>Brief Interview of Mental Status (BIMS) score of 3/15, indicating cognitive impairment. The MDS also indicated the resident had the psychiatric diagnoses of anxiety, depression, and psychotic disorder (other than schizophrenia).</p> <p>A Physician's order dated 11/12/12, indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered on an as-needed basis. A Physician's order dated 11/21/12, indicated the resident was to receive Seroquel (an anti-psychotic medication) 50 mg at bedtime and 25 mg in the morning.</p> <p>Interview with the Social Services Director on 2/22/13 at 8:55 a.m., indicated the Ativan was used to treat anxiety and the Seroquel was an anti-depressant medication.</p> <p>Review of the resident's 1/21/13 Care Plan, indicated there were no interventions for symptoms of depression.</p> <p>Further interview with the Social Service Director, indicated, "We do not do tracking for depression. We do a Care Plan for it. We look in Nurses' notes and watch for new and</p>		<ul style="list-style-type: none"> A comprehensive care plan for Resident #65's has been initiated related to her diagnosis of depression. Resident # 131 no longer resides in our facility. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents with a diagnosis of depression have the potential to be affected by the alleged deficient practice. Social Services will review all residents with a diagnosis of depression to ensure they have an appropriate corresponding comprehensive care plan. Social Services and the Interdisciplinary team will review psychoactive medication use within the first 5 days of admission to determine past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. 				

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	<p>worsening behavior."</p> <p>2. The record for Resident #131 was reviewed on 2/22/13 at 3:27 p.m. The Minimum Data Set (MDS) assessment dated 12/18/12, indicated the resident was diagnosed with "mild depression" with no behaviors and had a BIMS (Brief Interview for Mental Status) score of 13/15, indicating he was cognitively intact.</p> <p>Review of the February 2013 Physician orders summary (POS), indicated diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease, Ataxia, Bladder Cancer, Dementia, Altered Mental state, Falls, acute renal Failure, Epilepsy, Dementia with Delusions, Anxiety, Mild Encephalopathy and Insomnia. The POS indicated the resident was prescribed Trazadone (an anti-depressant) 50 milligrams (mg) 1 hour before bedtime and Paroxetine (an antidepressant medication) 20 mg in the morning and 10 mg in the evening.</p> <p>A 2/15/13 Physician's progress note, indicated the resident had also been receiving Remeron (an anti-depressant) but it was discontinued because the resident "states that he feels too sedated</p>				<ul style="list-style-type: none"> · Social Services will review each resident's PHQ9 score, psychoactive medication use and recent progress notes during the MDS assessment period. · Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met. · The Charge Nurse is responsible to follow-up on consultation orders as needed. · The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>		

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	<p>(since starting Remeron)."</p> <p>Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for "the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. The resident's record did not contain a Care Plan for depression.</p> <p>Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated there was no care plan written for symptoms of depression and she indicated she would need to find out why the resident was on medications used to treat depression.</p> <p>3.1-35(a)</p>			<ul style="list-style-type: none"> The Interdisciplinary Team was re-educated on the importance of having a comprehensive care plan related to depression for those residents with a diagnosis of depression by the Social Services consultant on 3/8/13. Nurses received re-educated on the importance of having a comprehensive care plan related to depression for those residents with a diagnosis of depression by Social Services by March 24, 2013. Social Services will review all residents with a diagnosis of depression to ensure they have an appropriate corresponding comprehensive care plan. Social Services and the Interdisciplinary team will review psychoactive medication use within the first 5 days of admission to determine past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. Social Services will review each resident's PHQ9 score, psychoactive medication use and recent progress notes during the MDS assessment period. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed 			

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				<p>and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met.</p> <ul style="list-style-type: none"> The Charge Nurse is responsible to follow-up on consultation orders as needed. The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool titled "SS Care Plan" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at 			

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				<p>least six months to ensure compliance with assessment and documentation procedures.</p> <p>· The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>· The Director of Nursing Services and the Social Service Director or their designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to ensure oral care was provided on a regular basis for 1 of 3 residents reviewed for activities of daily living of the 7 residents who met the criteria for activities of daily living. (Resident # 76)</p> <p>Findings include:</p> <p>Interview with Resident #76's family on 2/19/13 at 1:04 p.m., indicated the resident was not getting her dentures soaked on a routine basis.</p> <p>On 2/21/13 at 8:44 a.m., the record for Resident #76 was reviewed. The resident's diagnoses included, but were not limited to, arthritis, osteoporosis, dementia, and depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 1/16/13, indicated the resident was extensive one person assistance for personal hygiene.</p>		F0312	<p>F 312 ADL Care provided for Dependent Residents</p> <p>It is the practice of this provider to ensure that oral care is provided for those residents needing assistance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #76's dentures are cleaned on a regular basis as she will allow. Her aide assignment sheet and her health care plan have been updated.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>		03/24/2013	

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	<p>Interview with CNA #3 on 2/22/13 at 9:31 a.m., indicated she assisted the resident in dental care by setting up her toothbrush and helping her brush her teeth as necessary. CNA #3 indicated she believed the resident had all of her natural teeth. Review of the daily ADL (activities of daily living) sheet used by the CNA's, indicated denture care was not listed. Throughout the day on 2/22/13, the resident refused to open her mouth for an oral inspection.</p> <p>On 2/22/13 at 11:12 a.m., interview with LPN #4, indicated the resident's admission note dated 10/19/12, indicated the resident had upper and lower dentures.</p> <p>During an interview on 2/22/13 at 1:36 p.m., the MDS Coordinator verified the resident did have upper and lower dentures. The MDS Coordinator indicated, the resident had been incorrectly assessed as having her natural teeth and did not have a care plan for dentures.</p> <p>3.1-38(a)(3)(C) 3.1-38(b)(1)</p>				<ul style="list-style-type: none"> Residents requiring assistance with oral care have the potential to be affected by the deficient practice. All aide assignment sheets were audited to ensure they have the correct dental information. They will be reviewed and updated as needed. The DNS or her designee will conduct daily rounds to ensure the aide assignment sheets are being followed regarding dental care. Health care plans have been updated for those residents that refuse oral care. They will be reviewed on a quarterly basis and as needed. MDSs have been reviewed to ensure the correct dental information is recorded. They will be reviewed on a quarterly basis and as needed. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Nursing staff will be re-educated by March 24, 2013 by the SDC/designee. The DNS or her designee will conduct daily rounds to ensure the aide assignment sheets are being followed regarding dental care. 		

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				<ul style="list-style-type: none"> All aide assignment sheets were audited to ensure they have the correct dental information. They will be reviewed on a daily basis. Health care plans have been updated for those residents that refuse oral care. They will be reviewed on a quarterly basis and as needed. MDSs have been reviewed to ensure the correct dental information is recorded. They will be reviewed on a quarterly basis and as needed. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool "Dental Services" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures for physician orders. The CQI committee reviews the audits monthly and 			

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				<p>action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>· The Director of Nursing Services or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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F0329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure there were adequate indications for the use of psychoactive medications for 4 residents and the continued use of an antifungal drug for 1 resident who received an antifungal drug. This affected 5 of 10 residents reviewed for unnecessary medication use. (Residents #87, #61, #65, #130 and #131)</p>		F0329	<p>F329 Unnecessary Drugs</p> <p>It is the practice of this provider to ensure that there are adequate indications for the use of psychoactive medications.</p> <p>What corrective action(s) will be accomplished for those residents found to have been</p>		03/24/2013	

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	<p>Findings include:</p> <p>1. Observation and interview of Resident #87 on 2/18/13 at 2:00 p.m., indicated the resident was alert to person, place and time. The resident responded appropriately to several questions and provided good insight to answers.</p> <p>The record for Resident #87 was reviewed on 2/20/13 at 11:00 a.m. and indicated the resident was admitted in July 2012 with diagnoses including, but not limited to: dementia with behavioral disturbance, dementia with delusions, depression and anxiety. The physician orders indicated the resident received Risperdal (an anti-psychotic medication) 0.25 milligrams (mg) in the morning, Risperdal 0.25 mg in the evening and Lexapro (an anti-depressant medication) 10 mg every day.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/1/12, indicated a Brief Interview for Mental Status (BIMS) of 13/15, indicating minimal cognitive deficit. The MDS indicated the resident had no behavior or mood problems and received antipsychotic drugs and an antidepressant seven days a week.</p>				<p>affected by the deficient practice?</p> <ul style="list-style-type: none"> The physician orders for residents #87, #61, #65, and #130 are being followed. Resident #131 no longer resides in the facility. The consultant pharmacist reviewed Residents #87, #61, #65, and #130 medications to ensure that they are free from unnecessary drugs, making recommendations as needed. Residents #87, #61, #65, and #130 medication regimens are reviewed routinely for a gradual dose reduction as required per state regulation. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents receiving psychoactive medication have the potential to be affected by the alleged deficient practice. Before any resident receives a new order for a psychoactive drug they will be thoroughly assessed by the physician for the use of the medication. 		

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	<p>The 10/27/12 and 1/18/13, Quarterly MDS assessments, indicated a BIMS of 15/15 (no cognitive deficit) and no behavioral or mood problems. The resident continued to receive antipsychotic drugs seven days a week and an antidepressant seven days a week.</p> <p>Interview with the Social Service Director (SSD) on 2/20/13 at 2:27 p.m., indicated when the resident was admitted to the facility, the resident's husband was asked why the resident was receiving the drugs and he indicated it was due to delusions. The SSD indicated the non-pharmacological interventions were to encourage activities and the resident's husband took her out for short stays. The SSD reported the facility used monthly flow sheets to monitor the resident's behaviors. Review of the monthly flow sheets for December 2012, January 2013 and February 2013, indicated the resident had one incident of verbal distress in December 2012.</p> <p>Record review indicated there were no clinical contraindications listed as to why the psychoactive drugs could not be reduced.</p>				<ul style="list-style-type: none"> · Social Services and the Interdisciplinary team will review psychoactive medication use within the first 5 days of admission to determine past and present behaviors/moods exhibited, and appropriate diagnosis and indication for use. · A comprehensive care plan will be created for assessment and tracking of the medication. · Social Services will audit the Gradual Dose Reduction tracker on a routine basis. · Social Services will review care plans for residents using psychoactive medication for continued indication for use and placement. · A consultant pharmacist reviews each resident's medication regimen routinely but no less than monthly to ensure that they are free from unnecessary drugs, making recommendations as needed. · Residents receiving psychoactive medication are reviewed routinely for a gradual dose reduction as required per state regulation. · Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the 		

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	<p>On 2/22/13 at 11:00 a.m., the Executive Director was informed of the concerns regarding the continued use of the psychoactive drugs and requested any additional information available. She indicated the resident was being seen by the psychological services she had seen before admission to the facility. A request was made of the progress notes.</p> <p>On 2/22/13 at 11:30 a.m., the Director of Nursing was informed of the lack of information regarding the continued use of the psychoactive drugs and requested any additional information available.</p> <p>On 2/22/13 at 1:30 p.m., the SSD provided behavior flow sheets which were blank and Section D of the MDS for mood. No other information was provided to indicate the resident was being seen by psychological services or that the drugs were reviewed for continued need.</p>				<p>weekends and holidays, as needed, to ensure resident needs are met.</p> <ul style="list-style-type: none"> The Charge Nurse is responsible to follow-up on consultation orders as needed. The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff has been re-inserviced on completing the new/worsening behavior event prior to PRN psychoactive medication use or a new order for psychoactive medication by Social Services by March 24, 2013. Social Services and the Interdisciplinary Team will conduct chart reviews of those 		

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				<p>residents prescribed psychoactive medication to determine the appropriateness of use and interventions.</p> <ul style="list-style-type: none"> · Within the first 5 days of admission Social Services will review a resident's psychoactive medication use to determine past and present behaviors/moods exhibited and appropriate diagnosis and indication for use. · A comprehensive care plan will be created for assessment and tracking of the medication. · Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met. · The Charge Nurse is responsible to follow-up on consultation orders as needed. · The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is 			

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					<p>notified by the charge nurse of pertinent information on the weekends and holidays, as needed.</p> <p>· Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>· The CQI tool "Psychoactive Management" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures.</p> <p>· The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>· The Director of Nursing</p>		

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	<p>2. The record for Resident #130 was reviewed on 2/21/13 at 10:29 a.m.</p> <p>A Physician's order dated 12/18/12, indicated the resident was to receive an antifungal cream to excoriated areas below her bilateral breasts every shift until healed.</p> <p>Review of the December 2012 Medication Administration Record (MAR), indicated the cream had been signed out every shift from 12/19-12/31/13.</p> <p>Review of the January 2013 MAR, indicated the cream had been signed out every shift for the entire month.</p> <p>The February 2013 MAR, indicated the cream had been signed out every shift from 2/1-2/21/13.</p> <p>Review of the Weekly Skin Assessments dated 2/12/13, 2/5/13, 1/28/13, 1/21/13, 1/8/13 and 1/1/13, indicated the resident had no skin</p>			<p>Services or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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	<p>issues and there was no documentation related to excoriation underneath the resident's breasts.</p> <p>Interview with the resident on 2/21/13 at 3:35 p.m., indicated the cream underneath her breasts was still being applied by staff.</p> <p>Interview with the BCD Unit manager on 2/22/13 at 9:10 a.m., indicated the resident's rash was gone and that she should no longer be receiving the anti-fungal cream.</p> <p>3. The record for Resident #65 was reviewed on 2/20/13 at 10:51 a.m. A Physician's order dated 11/12/12, indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered on an as-needed basis. A Physician's order dated 11/21/12, indicated the resident was to receive Seroquel (an anti-psychotic medication) 50 mg at bedtime and 25 mg in the morning.</p> <p>Interview with the Social Services Director on 2/22/13 at 8:55 a.m., indicated the Ativan was used to treat anxiety and the Seroquel was an anti-depressant medication.</p>						

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	<p>Resident #65's February 2013 Medication Administration Record (MAR) listed diagnoses, which included, but were not limited to, Alzheimer's, Parkinson's, Depression, Adjustment Disorder, Worsening of Alzheimer's, Behaviors with Delusions, Insomnia, anxiety. Review of the resident's 1/21/13 Care Plan, indicated there were no interventions for symptoms of depression. Review of the December 2012, January and February 2013 Medication Administration Records, indicated Ativan was not needed as an intervention in over 60 days. The record did not indicate the continued use of the medication was justified.</p> <p>Further interview with the Social Service Director, indicated the facility had just began a new system in the past month in reassessing for the need of medications as behavioral interventions. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence there had been ongoing reassessment of the resident's use of psychoactive medications. Additionally the Social Service Director indicated, "We do not do tracking for depression. We do Care Plan for it. We look in Nurses' notes</p>						

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	<p>and watch for new and worsening behavior."</p> <p>4. Observation on 2/18/13 at 12:20 p.m., during the lunch meal, staff were unable to get Resident #61 to open his eyes while sitting at the lunch table. The resident had been observed sitting with his eyes closed in the late morning prior to lunch while other residents were involved in activities. Observations on 2/19 at 11:00 a.m. and 2/20/13 at 2:45 p.m., found the resident in the dayroom sitting in a chair with his eyes closed.</p> <p>Review of Resident #61's February 2013 Medication Administration Record (MAR) on 2/20/13 at 10:59 a.m., indicated the resident's diagnoses, included but were not limited to, Alzheimer's with tremors, hypertension, chronic constipation, meningioma, insomnia, dementia with agitation, and depression. The MAR, indicated the resident was receiving Melatonin (an herbal supplement for sleep) 5 milligrams (mg) daily at bedtime. Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated the Melatonin was used to treat insomnia.</p> <p>The resident's care plan updated on 1/31/13, indicated the following</p>						

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	<p>interventions for Insomnia; pain management, reposition, and encourage resident to be awake in day.</p> <p>Further interview with the Social Service Director, indicated the facility had just began a new system in the past month in reassessing for the need of medications. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence there had been ongoing reassessment of the resident's use of Melatonin. The Social Service Director indicated the resident "had no insomnia last month or this month." The Social Service Director indicated no meeting with the physician had yet occurred to reassess the resident's need for the medication.</p> <p>5. The record for Resident #131 was reviewed on 2/22/13 at 3:27 p.m. The Minimum Data Set (MDS) assessment dated 12/18/12, indicated the resident was diagnosed with "mild depression" with no behaviors and had a BIMS (Brief Interview for Mental Status) score of 13. Review of the February 2013 Physician orders summary (POS), indicated diagnoses including, but not limited to, Chronic</p>						

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	<p>Obstructive Pulmonary Disease, Ataxia, Bladder Cancer, Dementia, Altered Mental state, Falls, acute renal Failure, Epilepsy, Dementia with Delusions, Anxiety, Mild Encephalopathy and Insomnia. The POS indicated the resident was prescribed Trazadone (an anti-depressant) 50 milligrams (mg) 1 hour before bedtime, Namenda (a medication to treat Alzheimer's) 5 mg twice daily, Diazepam (an anti-anxiety medication) 5 mg twice daily, and Paroxetine (an antidepressant medication) 20 mg in the morning and 10 mg in the evening.</p> <p>A 2/15/13 Physician's progress note, indicated the resident had also been receiving Remeron (an anti-depressant) but it was discontinued because the resident "states that he feels too sedated (since starting Remeron)."</p> <p>Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for "the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. However, the January 2013 and February 2013 Behavior Tracking Flow Sheets, indicated those behaviors had not been exhibited</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>since the care plan was initiated. There was no indication in the resident's record indicating an assessment had been completed to determine a need for the medications. Further, the resident's record did not contain a Care Plan for depression nor justification as to why the medications used to treat depression were required.</p> <p>Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated there was no care plan written for symptoms of depression and she indicated she would need to find out why the resident was on medications used to treat depression.</p> <p>3.1-48(a)(4) 3.1-48(b)(2)</p>						

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F0334 SS=C	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>						

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure written notice related to risks and benefits of an annual influenza vaccine was provided to 5 of 5 residents reviewed for influenza and pneumococcal vaccines. (Residents #7, #16, #28, #68, and #138)</p> <p>Findings include:</p> <p>During the Infection control investigation on 2/22/13 at 2:00 p.m., indicated Residents #7, #16, #28, #68, and #138 had not received a written notice of the risks and</p>	F0334	<p>F334 Influenza and Pneumococcal Immunizations</p> <p>It is the practice of this provider to ensure that written notice related to risks and benefits of an annual influenza vaccine is provided to all residents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	03/24/2013			

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	<p>benefits of receiving the influenza vaccination.</p> <p>Interview with the Staff development Coordinator on 2/22/13 at 3:15 p.m., indicated no written information was being given related to the flu vaccine, just verbal information.</p> <p>3.1-13(a)</p>				<p>Residents #7, #16, #28, #68 and #138 have all received written notice related to risks and benefits of an annual influenza vaccine is provided to all residents.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>An audit was conducted of resident records to ensure that residents who declined the flu vaccination received written notice related to the risks and benefits of an annual flu vaccination.</p> <p>At admission all residents receive written notice related to risks and benefits of an annual flu vaccination.</p> <p>Written notice related to the risks and benefits of an annual influenza vaccine will be given to residents on a yearly basis when consents are updated.</p> <p>What measures will be put into place or what systemic</p>		

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					<p>changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Written notice related to the risks and benefits of an annual influenza vaccine will be given to residents on a yearly basis when consents are updated. At admission all residents receive written notice related to risks and benefits of an annual flu vaccination. The infection control nurse was re-educated about the importance of providing residents with written notice related to the risks and benefits of an annual influenza vaccine by March 24, 2013 by the Executive Director. The Infection Control Nurse or her designee will review all new admission records within a week to ensure that they received written notice related to the risks and benefits of an annual influenza vaccine. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>		

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				<p>i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool "Resident Immunizations" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with obtaining and documenting radiology results. The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education or disciplinary action. The Director of Nursing Services or her designee is responsible to monitor for compliance. Compliance Date: March 24, 2013 			

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, interview and record review, the facility failed to ensure the pharmacist provided monthly reviews regarding the continued use of an antipsychotic drug for 1 of 10 residents reviewed for unnecessary drugs. (Resident #87)</p> <p>Findings include:</p> <p>Observation and interview of Resident #87 on 2/18/13 at 2:00 p.m., indicated the resident was alert to person, place and time. The resident responded appropriately to several questions and provided good insight to answers.</p> <p>The record for Resident #87 was reviewed on 2/20/13 at 11:00 a.m. and indicated the resident was admitted in July 2012 with diagnoses including, but not limited to: dementia with behavioral disturbance and dementia with delusions. The physician orders indicated the</p>		F0428	<p>F428 Drug Regimen Review, Report Irregular, Act On</p> <p>It is the practice of this provider to ensure that the pharmacist provides monthly reviews regarding the continued use of antipsychotic drugs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The pharmacist has reviewed Resident #87's antipsychotic drug use and made recommendations as needed.</p> <p>How will you identify other residents having the potential to be affected by the same deficient</p>		03/24/2013	

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	<p>resident received Risperdal (an anti-psychotic medication) 0.25 milligrams (mg) in the morning and 0.25 mg in the evening.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/1/12, indicated a Brief Interview for Mental Status (BIMS) of 13/15, indicating minimal cognitive deficit. The MDS indicated the resident had no behavior or mood problems and received antipsychotic drugs seven days a week.</p> <p>The 10/27/12 and 1/18/13, Quarterly MDS assessments, indicated a BIMS of 15/15 (no cognitive deficit) and no behavioral or mood problems. The resident continued to receive antipsychotic drugs seven days a week.</p> <p>Interview with the Social Service Director (SSD) on 2/20/13 at 2:27 p.m., indicated the facility used monthly flow sheets to monitor the resident's behaviors. Review of the monthly flow sheets for December 2012, January 2013 and February 2013, indicated the resident had one incident of verbal distress in December 2012.</p> <p>Record review indicated there was no</p>			<p>practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents that receive an antipsychotic drug have the potential to be affected by the alleged deficient practice. The consultant pharmacist will review the drug regimen of each resident receiving a psychoactive medication at least once a month. The pharmacist will provide monthly reviews regarding the continued use of antipsychotic medication use for residents receiving psychoactive medication. Social Services will review the monthly pharmacist report to ensure all residents receiving psychoactive medications have been reviewed. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The consultant pharmacist will review the drug regimen of each resident receiving a psychoactive medication at least once a month. The pharmacist will provide monthly reviews regarding the continued use of antipsychotic medication use for residents receiving psychoactive medication. 			

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	<p>clinical contraindications listed as to why the psychoactive drugs could not be reduced.</p> <p>There was no indication there were any recommendations regarding the lack of behaviors requiring the use of the antipsychotic drug. There were no recommendations regarding the use of the antipsychotic drug until 1/7/13 when the pharmacist requested a dose reduction.</p> <p>On 2/22/13 at 11:00 a.m., the Executive Director was informed of the concerns regarding the continued use of the psychoactive drugs and requested any additional information available. No further pharmacist recommendations were provided at the end of the survey.</p> <p>3.1-25(i)</p>				<ul style="list-style-type: none"> Social Services will review the monthly pharmacist report to ensure all residents receiving psychoactive medications have been reviewed. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool "Unnecessary Medications" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with obtaining and documenting radiology results. The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education or disciplinary action. The Director of Nursing 		

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F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the nurses' station was equipped to receive a resident call light for 1 of 9 rooms on the 2 North unit. (Room #247)</p> <p>Findings include:</p> <p>On 2/18/13 at 2:15 p.m., the call light located next to Resident #135's bed in room #247, did not function when pressed. The call light did not illuminate at the nurses' station either. Interview with the Assistant Director of Nursing at this time, indicated the resident's call light was not working and she would notify maintenance.</p> <p>Two residents resided in this room.</p> <p>3.1-19(u)(1)</p>			F0463	<p>F463 Resident Call System-Rooms/Toilet/Bath</p> <p>It is the practice of this provider to ensure that the nurses' station is equipped to receive resident call lights.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· The call light for Room #247 was repaired immediately.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents have the</p>		03/24/2013

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					<p>potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> All call lights in the building have been checked to ensure they sound at the nurse's station. Customer Service Representatives were inserviced by March 24, 2013 related to checking call light function routinely with room rounds by the Maintenance Supervisor. Call light function will be checked during the Customer Service Representative room checks to ensure they are sounding at the nurse's station. Housekeeping staff were inserviced by March 24, 2013 related to checking call light function routinely by the Maintenance Supervisor. Housekeeping will check the call lights on a routine basis to ensure they are sounding at the nurse's station. Maintenance will check call light function according to the preventative maintenance schedule and as needed to ensure they are sounding at the nurse's station. <p>What measures will be put into place or what systemic</p>		

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				<p>changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Customer Service Representatives were inserviced by March 24, 2013 related to checking call light function routinely with room rounds by the Maintenance Supervisor. Call light function will be checked during the Customer Service Representative room checks to ensure they are sounding at the nurse's station. Housekeeping staff were inserviced by March 24, 2013 related to checking call light function routinely by the Maintenance Supervisor. Housekeeping will check the call lights on a routine basis to ensure they are sounding at the nurse's station. Maintenance will check call light function according to the preventative maintenance schedule and as needed to ensure they are sounding at the nurse's station. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. 			

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				<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool titled "Weekly Tasks" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly for at least six months thereafter to ensure compliance with assessment and documentation procedures. The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. The Maintenance Supervisor or his designee is responsible to monitor for compliance. <p>Compliance Date: March 24, 2013</p>			

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F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents, related to walls, doors, and trim with chipped paint, chipped handrail, wallpaper in disrepair, and a hazard potential in relation to a motion sensor. This had the potential to affect all 92 residents who reside in the facility.</p> <p>Findings include:</p> <p>During the Environmental tour on 2/21/13 at 9:32 a.m., with the Maintenance Director and the Housekeeping Manager, the following was observed:</p> <p>1. C Hall:</p> <p>a. There was chipped paint on the entry door to C Hall.</p> <p>b. The common shower area had a loose outlet cover for the heated overhead light and a piece of loose floor trim in the entryway. Fourteen residents resided on this hall.</p>			F0465	<p>F465 Environment</p> <p>It is the practice of this provider to ensure that the facility provides a safe, sanitary, and comfortable environment for residents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The entry door to C hall has been painted. · The loose outlet cover for the heated overhead light and the floor trim in the entry way to shower area on C hall have been repaired. · The exterior side of room #132's door was cleaned and repainted. · The door frame to the bathroom of room #125 has been repaired and repainted. · The door to room #128 was repainted. · The caulk around the toilet in room #128 was replaced and the wall was cleaned. · The closet door of room #128 was repaired and</p>		03/24/2013

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	<p>c. The exterior side of room #132's door was scuffed and room #128's door had chipped paint. The door frame to the bathroom of room #125 was chipped and marred. In room #128, the caulk around the toilet was discolored in the bathroom and the wall was stained. The closet door of room #128 had chipped and marred paint. One resident resided in room #125, one resident resided in room #128, and one resident resided in room #132.</p> <p>2. D Hall:</p> <p>a. There was chipped paint along the door frame of entry.</p> <p>b. In room #139, the dresser drawers were scratched and marred. There were dead insects in the light fixture of the bathroom. One resident resided in this room.</p> <p>3. 1 North:</p> <p>a. Room #143 had areas of the walls next to hand towel dispenser that were in disrepair and the arms of the commode were chipped. Two residents resided in this room.</p> <p>b. Room #149 had chipped paint around the sink in the bathroom and</p>		<p>repainted. · The entry door frame to D hall has been repainted. · The dresser in room #139 has been repaired and the light fixture in the bathroom has been cleaned. · In room #143 on 1 North, the walls next to the hand towel dispenser have been repaired and the arms of the commode have been replaced. · In room #149, the wall around the bathroom sink has been repainted and the walls have been cleaned. The overhead light above the bed has been repaired. The motion sensor has been moved and the aide assignment sheet updated to indicate proper placement. · The chipped handrail at the corner near the entrance of 1 West has been repaired. · On 2 West, the divots in the entry floor linoleum have been repaired. · The missing square of handrail near the exit on 2 West has been replaced. · The wall in the 2 West dining room has been repaired and the floor has been repaired. · In room #269, the base board has been repaired and the wall has been repainted near the heating unit. The bedside stand has been repaired. · The bathroom door in room #262 has been cleaned, repaired and repainted. The privacy curtain has been cleaned. The dresser has been repaired. · In room #273, the bathroom walls and the edge of the entry door to the room have been repaired and</p>				

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	<p>scuff marks on the walls. The overhead light above the bed did not work. A motion sensor was observed to be in the middle of the floor between the bed, dresser, and television. Two residents resided in this room.</p> <p>4. 1 West:</p> <p>a. A chipped handrail was observed on the corner near the entrance.</p> <p>5. 2 West:</p> <p>a. The entry floor had 3 divots in the linoleum approximately 2 inches by 1 inch.</p> <p>b. There was a missing square of handrail near the exit.</p> <p>c. There was a missing section of wallpaper in the dining room and several divots were observed in the floor near the dining room entry. Twenty-four residents resided on this unit.</p> <p>d. Room #269 had a base board loose and paint peeling near the heating unit. The bedside stand with 3 drawers had scratches and were marred. Two residents resided in this room.</p>				<p>repainted. · On 2 North, the bathroom door in room #246 has been repaired and repainted. The caulk around the toilet has been replaced. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · Customer Service Representatives were inserviced by March 24, 2013 related to noting any needed repairs and reporting them to the Maintenance Supervisor. · During Customer Service room rounds, the Customer Service Representative will note any needed repairs and report them to the Maintenance Supervisor. · Housekeeping staff were inserviced by March 24, 2013 related to noting any needed repairs and reporting them to the Maintenance Supervisor. · During daily cleaning, Housekeeping staff will note any needed repairs and report them to the Maintenance Supervisor. · The Maintenance Supervisor or his designee will be responsible to ensure that all repairs are completed within a reasonable time frame. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Customer Service</p>		

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	<p>c. The bathroom door in Room #262 was paint chipped and marred on both sides of the bathroom door. The privacy curtain was stained and the 3 drawer dresser was scratched. Two residents resided in this room.</p> <p>d. Room #273 had chipped paint on the bathroom walls and peeling paint on the edge of the door in the entry of the room. Two residents resided in this room.</p> <p>6. 2 North:</p> <p>a. Room #246 had a scratched and marred door inside the bathroom. Caulk around the base of the toilet was discolored.</p> <p>3.1-19(f)</p>			<p>Representatives were inserviced by March 24, 2013 related to noting any needed repairs and reporting them to the Maintenance Supervisor. · During Customer Service room rounds, the Customer Service Representative will note any needed repairs and report them to the Maintenance Supervisor. · Housekeeping staff were inserviced by March 24, 2013 related to noting any needed repairs and reporting them to the Maintenance Supervisor. · During daily cleaning, Housekeeping staff will note any needed repairs and report them to the Maintenance Supervisor. · The Maintenance Supervisor or his designee will be responsible to ensure that all repairs are completed within a reasonable time frame. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The CQI tools titled "Quality Control Inspection-Housekeeping and Preventative Maintenance Performed this Month" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with</p>			

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				<p>assessment and documentation procedures. · The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. · The Maintenance Supervisor or his designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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F0502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure hemoccult stool tests were completed for 2 of 2 residents who had orders for hemoccults of the 10 who were reviewed for unnecessary medications. (Residents #68 and #139)</p> <p>Findings include:</p> <p>1. The record for Resident #68 was reviewed on 2/20/13 at 9:39 a.m. The resident's diagnosis included, but was not limited to, anemia.</p> <p>A Physician's order dated 2/4/13, indicated the resident was to have a hemoccult stool test (a test to check for blood in the stool) times three.</p> <p>Review of the bowel movement tracking record indicated the resident had bowel movements on 2/6 at 9:05 p.m., 2/8 at 9:32 a.m., 2/13 at 7:54 p.m., and 2/18/13 at 11:16 a.m.</p> <p>Interview with the Second floor Unit manager on 2/22/13 at 8:55 a.m., indicated the resident did have an</p>			F0502	<p>F502 Administration</p> <p>It is the practice of this provider to ensure that hemoccult stool tests are completed.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· The hemoccult stool tests for residents #68 and #139 were obtained and sent to the lab for testing.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents who receive a physician's order for a hemoccult stool test have the potential to be affected.</p> <p>· An audit will be completed</p>		03/24/2013

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	<p>order for hemocult tests and two stool samples had been obtained on 2/21/13. She indicated the stool samples should have been obtained in a more timely manner.</p> <p>2. The record for Resident #139 was reviewed on 2/20/13 at 8:48 a.m. The resident's diagnoses included, but were not limited to, malnutrition and incontinence.</p> <p>A Physician's order dated 2/14/13, indicated the resident was to have a hemocult stool sample (a test to check for blood in the stool) times three. The resident was also to have a stool sample obtained for helicobacter pylori (h. pylori) (a bacteria in the stomach).</p> <p>Review of the bowel movement tracking record, indicated the resident had a bowel movement on 2/17 at 12:58 p.m., 2/18 at 9:23 a.m. and 1:40 p.m., and 2/20/13 at 2:19 p.m.</p> <p>Interview with the Second floor Unit manager on 2/22/13 at 8:53 a.m., indicated the stool for hemmocult and h. pylori had not been collected as ordered.</p> <p>3.1-49(a)</p>				<p>of resident orders to determine if any other hemocult stool tests have been ordered.</p> <ul style="list-style-type: none"> When a hemocult stool test order is received it will be entered into hot charting until obtained. Monthly at rewrite verification the Unit Manager or designee will audit for routine hemocult stool test orders and place into hot charting until obtained. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Nursing staff were re-educated by March 24, 2013 on the proper procedure for tracking hemocult stool tests by the SDC/designee. When a hemocult stool test order is received it will be entered into hot charting until obtained. Monthly at rewrite verification the Unit Manager or designee will audit for routine hemocult stool test orders and place into hot charting until 		

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				<p>obtained.</p> <ul style="list-style-type: none"> Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tool "Labs/Diagnostics" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures. The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. The Director of Nursing Services or her designee is responsible to monitor for compliance. 			

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F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to ensure the quality assessment and assurance committee identified and implemented an appropriate plan of action related to monitoring psychoactive medications and ensuring there was an indication for the use of the medication. This had the potential to affect 4 of 10 residents reviewed for unnecessary medications. (Residents #61, #65,</p>			F0520	<p>F520 QAA Committee-Members/Meet Quarterly/Plans</p> <p>It is the practice of this provider to ensure the quality assessment and assurance committee identifies and implements an appropriate plan of action related to monitoring psychoactive medications and ensuring there is an indication for the</p>		03/24/2013

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	<p>#87 and #131)</p> <p>Findings include:</p> <p>1. Interview with the Executive Director on 2/22/13 at 2:00 p.m., indicated the facility was focusing on Gradual dose reductions for psychoactive medications and not focusing as much on monitoring behaviors for residents who were receiving psychoactive medications and ensuring there were indications for the use of psychoactive medications.</p> <p>2. Observation and interview of Resident #87 on 2/18/13 at 2:00 p.m., indicated the resident was alert to person, place and time. The resident responded appropriately to several questions and provided good insight to answers.</p> <p>The record for Resident #87 was reviewed on 2/20/13 at 11:00 a.m. and indicated the resident was admitted in July 2012 with diagnoses including, but not limited to: dementia with behavioral disturbance, dementia with delusions, depression and anxiety. The physician orders indicated the resident received Risperdal (an anti-psychotic medication) 0.25 milligrams (mg) in</p>				<p>use of the medication.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> The physician orders for residents #87, #61, #65, and #130 are being followed. Resident #131 no longer resides in the facility. The consultant pharmacist reviewed Residents #87, #61, #65, and #130 medications to ensure that they are free from unnecessary drugs, making recommendations as needed. Residents #87, #61, #65, and #130 medication regimens are reviewed routinely for a gradual dose reduction as required per state regulation. The Executive Director has ensured the monitoring of psychoactive medications and assurance of an indication for the use of the medication has been addressed through the QAA/CQI process and a plan of action has been developed and implemented. <p>How will you identify other</p>		

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	<p>the morning, Risperdal 0.25 mg in the evening and Lexapro (an anti-depressant medication) 10 mg every day.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/1/12, indicated a Brief Interview for Mental Status (BIMS) of 13/15, indicating minimal cognitive deficit. The MDS indicated the resident had no behavior or mood problems and received antipsychotic drugs and an antidepressant seven days a week.</p> <p>The 10/27/12 and 1/18/13, Quarterly MDS assessments, indicated a BIMS of 15/15 (no cognitive deficit) and no behavioral or mood problems. The resident continued to receive antipsychotic drugs seven days a week and an antidepressant seven days a week.</p> <p>Interview with the Social Service Director (SSD) on 2/20/13 at 2:27 p.m., indicated when the resident was admitted to the facility, the resident's husband was asked why the resident was receiving the drugs and he indicated it was due to delusions. The SSD indicated the non-pharmacological interventions were to encourage activities and the resident's husband took her out for</p>			<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Residents receiving psychoactive medication have the potential to be affected by the alleged deficient practice. A consultant pharmacist reviews each resident's medication regimen routinely but no less than monthly to ensure that they are free from unnecessary drugs, making recommendations as needed. Residents receiving psychoactive medication are reviewed routinely for a gradual dose reduction as required per state regulation. The Gradual Dose Reduction tracker will be updated with an audit of appropriate care plans showing clear indications for use for each resident receiving a psychoactive medication. Residents will be referred for discontinuation or Gradual Dose Reduction of psychoactive medication that does not have a clear indication of use, identified through monthly behavior summaries and meetings. Needs will be identified through CQI review, chart 			

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	<p>short stays. The SSD reported the facility used monthly flow sheets to monitor the resident's behaviors. Review of the monthly flow sheets for December 2012, January 2013 and February 2013, indicated the resident had one incident of verbal distress in December 2012.</p> <p>Record review indicated there were no clinical contraindications listed as to why the psychoactive drugs could not be reduced.</p> <p>On 2/22/13 at 11:00 a.m., the Executive Director was informed of the concerns regarding the continued use of the psychoactive drugs and requested any additional information available. She indicated the resident was being seen by the psychological services she had seen before admission to the facility. A request was made of the progress notes.</p> <p>On 2/22/13 at 11:30 a.m., the Director of Nursing was informed of the lack of information regarding the continued use of the psychoactive drugs and requested any additional information available.</p> <p>On 2/22/13 at 1:30 p.m., the SSD provided behavior flow sheets which were blank and Section D of the MDS</p>		<p>reviews, or monthly behavior reviews will be addressed through CQI communication forms.</p> <ul style="list-style-type: none"> · Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met. · The Charge Nurse is responsible to follow-up on consultation orders as needed. · The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. · The Executive Director will ensure the monitoring of psychoactive medications and assurance of an indication for the use of the medication is being addressed through the QAA/CQI process and a plan of action has been developed and implemented. · 				

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	<p>for mood. No other information was provided to indicate the resident was being seen by psychological services or that the drugs were reviewed for continued need.</p> <p>3. The record for Resident #65 was reviewed on 2/20/13 at 10:51 a.m. A Physician's order dated 11/12/12, indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be administered on an as-needed basis. A Physician's order dated 11/21/12, indicated the resident was to receive Seroquel (an anti-psychotic medication) 50 mg at bedtime and 25 mg in the morning.</p> <p>Interview with the Social Services Director on 2/22/13 at 8:55 a.m., indicated the Ativan was used to treat anxiety and the Seroquel was an anti-depressant medication.</p> <p>Resident #65's February 2013 Medication Administration Record (MAR) listed diagnoses, which included, but were not limited to, Alzheimer's, Parkinson's, Depression, Adjustment Disorder, Worsening of Alzheimer's, Behaviors with Delusions, Insomnia, anxiety. Review of the resident's 1/21/13 Care Plan, indicated there were no interventions</p>				<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff has been re-inserviced on completing the new/worsening behavior event prior to PRN psychoactive medication use or a new order for psychoactive medication by Social Services by March 24, 2013. Social Services and the Interdisciplinary Team will conduct chart reviews of those residents prescribed psychoactive medication to determine the appropriateness of use and interventions. Within the first 5 days of admission Social Services will review a resident's psychoactive medication use to determine past and present behaviors/moods exhibited and appropriate diagnosis and indication for use. A comprehensive care plan will be created for assessment and tracking of the medication. A consultant pharmacist reviews each resident's medication regimen routinely but no less than monthly to ensure that they are free from unnecessary drugs, making recommendations as needed. 		

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	<p>for symptoms of depression. Review of the December 2012, January and February 2013 Medication Administration Records, indicated Ativan was not needed as an intervention in over 60 days. The record did not indicate the continued use of the medication was justified.</p> <p>Further interview with the Social Service Director, indicated the facility had just began a new system in the past month in reassessing for the need of medications as behavioral interventions. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence there had been ongoing reassessment of the resident's use of psychoactive medications. Additionally the Social Service Director indicated, "We do not do tracking for depression. We do Care Plan for it. We look in Nurses' notes and watch for new and worsening behavior."</p> <p>4. Observation on 2/18/13 at 12:20 p.m., during lunch, staff were unable to get Resident #61 to open his eyes while sitting at the lunch table. The resident had been observed sitting with his eyes closed during observation in the late morning prior</p>				<ul style="list-style-type: none"> Residents receiving psychoactive medication are reviewed routinely for a gradual dose reduction as required per state regulation. The Gradual Dose Reduction tracker will be updated with an audit of appropriate care plans showing clear indications for use for each resident receiving a psychoactive medication. Residents will be referred for discontinuation or Gradual Dose Reduction of psychoactive medication that does not have a clear indication of use, identified through monthly behavior summaries and meetings. Needs will be identified through CQI review, chart reviews, or monthly behavior reviews will be addressed through CQI communication forms. Social Service is responsible to review resident behaviors with the Interdisciplinary Team at the clinical meeting Monday-Friday (excluding holidays). The resident's plan of care is reviewed and revised, as needed. Significant resident behaviors are reported to the nurse manager-on-call on the weekends and holidays, as needed, to ensure resident needs are met. 		

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	<p>to lunch while other residents were involved in activities. Observations on 2/19 at 11:00 a.m. and 2/20/13 at 2:45 p.m., found the resident in the dayroom sitting in a chair with his eyes closed.</p> <p>Review of Resident #61's February 2013 Medication Administration Record (MAR) on 2/20/13 at 10:59 a.m., indicated the resident's diagnoses, included but were not limited to, Alzheimer's with tremors, hypertension, chronic constipation, meningioma, insomnia, dementia with agitation, and depression. The MAR, indicated the resident was receiving Melatonin (an herbal supplement for sleep) 5 milligrams (mg) daily at bedtime. Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated the Melatonin was used to treat insomnia.</p> <p>The resident's care plan updated on 1/31/13, indicated the following interventions for Insomnia; pain management, reposition, and encourage resident to be awake in day.</p> <p>Further interview with the Social Service Director, indicated the facility had just began a new system in the past month in reassessing for the</p>				<ul style="list-style-type: none"> The Charge Nurse is responsible to follow-up on consultation orders as needed. The Interdisciplinary Team reviews Physician Orders and the 24 Hour Report, to ensure pertinent orders are referred to the appropriate departments. The orders from the weekend are reviewed on the next business day. The manager on duty is notified by the charge nurse of pertinent information on the weekends and holidays, as needed. The Executive Director will ensure the monitoring of psychoactive medications and assurance of an indication for the use of the medication is being addressed through the QAA/CQI process and a plan of action has been developed and implemented. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The CQI tools "Psychoactive Management, Behavior Management, SS Care Plan and Unnecessary Medications" will be utilized by the 		

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	<p>need of medications. The Social Service Director presented Behavior Flow sheets and indicated monthly review meetings were starting, but there was no evidence there had been ongoing reassessment of the resident's use of Melatonin. The Social Service Director indicated the resident "had no insomnia last month or this month." The Social Service Director indicated no meeting with the physician had yet occurred to reassess the resident's need for the medication.</p> <p>5. The record for Resident #131 was reviewed on 2/22/13 at 3:27 p.m. The Minimum Data Set (MDS) assessment dated 12/18/12, indicated the resident was diagnosed with "mild depression" with no behaviors and had a BIMS (Brief Interview for Mental Status) score of 13. Review of the February 2013 Physician orders summary (POS), indicated diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease, Ataxia, Bladder Cancer, Dementia, Altered Mental state, Falls, acute renal Failure, Epilepsy, Dementia with Delusions, Anxiety, Mild Encephalopathy and Insomnia. The POS indicated the resident was prescribed Trazadone (an anti-depressant) 50 milligrams (mg) 1</p>			<p>Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures.</p> <p>· The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>· The Executive Director or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>			

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	<p>hour before bedtime, Namenda (a medication to treat Alzheimer's) 5 mg twice daily, Diazepam (an anti-anxiety medication) 5 mg twice daily, and Paroxetine (an antidepressant medication) 20 mg in the morning and 10 mg in the evening.</p> <p>A 2/15/13 Physician's progress note, indicated the resident had also been receiving Remeron (an anti-depressant) but it was discontinued because the resident "states that he feels too sedated (since starting Remeron)."</p> <p>Review of the resident's 1/22/13 Care Plan, indicated the resident was admitted on 12/18/12. The resident's Care Plan included interventions for "the behavior of delusions of money taken and verbal aggression to staff" which were initiated on 1/8/13. However, the January 2013 and February 2013 Behavior Tracking Flow Sheets, indicated those behaviors had not been exhibited since the care plan was initiated. There was no indication in the resident's record indicating an assessment had been completed to determine a need for the medications. Further, the resident's record did not contain a Care Plan for depression nor justification as to why the medications used to treat depression</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>were required.</p> <p>Interview with the Social Service Director on 2/22/13 at 8:55 a.m., indicated there was no care plan written for symptoms of depression and she indicated she would need to find out why the resident was on medications used to treat depression.</p> <p>3.1-52(b)(2)</p>						

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R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure Physician prescribed medications were administered as ordered for 1 of 6 sampled residents related to insulin administration. This had the potential to affect the five insulin dependent diabetics who resided on Assisted Living. (Resident #5)</p> <p>Findings include:</p> <p>The record for Resident #5 was reviewed on 2/22/13 at 1:20 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, obesity, stage III chronic kidney disease, and coronary artery disease.</p> <p>Review of the Physician Order Statement (POS) for January 2013, indicated the resident was to have her blood sugar checked three times a day before meals. She was to receive Novolog (insulin, medication used to treat high blood sugars)</p>		R0241	<p>R241 Health Services</p> <p>It is the practice of this provider to ensure that physician prescribed medications are administered as ordered related to insulin administration.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· Resident #5's physician was contacted to clarify the insulin orders.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· Residents residing on</p>		03/24/2013	

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	<p>according to the following scale: blood sugars 70-100, no coverage; 111-151, 1 unit; 151-200, 2 units; 201-250, 4 units; 251-300, 6 units; 301-350, 8 units; 351-400, 10 units; and greater than 500, 12 units and call the physician.</p> <p>Review of the January 2013 Capillary Blood Glucose Monitoring Tool, indicated on 1/8/13 at 11:30 a.m., the resident's blood sugar was 411, the resident received 10 units of insulin. There was no order from the physician for any insulin coverage. On 1/10/13 at 6:00 a.m., the resident's blood sugar was 189. The resident did not receive any insulin. The resident should have received 2 units. On 1/30/13 at 4:00 p.m., the resident's blood sugar was 305. The resident received 9 units of insulin and she should have received 8 units of insulin.</p> <p>Review of the POS for February 2013, indicated the resident was to have her blood sugar checked four times a day, before meals and at bedtime. She was to receive Novolog (insulin, medication used to treat high blood sugars) according to the following scale: blood sugars 70-100, no coverage; 111-151, 1 unit; 151-200, 2 units; 201-250, 4 units;</p>			<p>Assisted Living with insulin administration orders have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> All residents on Assisted Living who have insulin orders had their orders audited for accuracy. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Re-education for nurses was given by the SDC by March 24, 2013. Blood Glucose monitoring flow sheets for Assisted Living residents with insulin orders have been added to the Diabetic Monitoring book for the BCD unit. The Unit Manager or her designee is responsible to audit this book daily. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. <p>How the corrective action(s) will be monitored to ensure the</p>			

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	<p>251-300, 6 units; 301-350, 8 units; 351-400, 10 units; and greater than 500, 12 units, and call the physician for blood sugars less than 60 or greater than 500.</p> <p>Review of the February 2013 Capillary Blood Glucose Monitoring Tool, indicated on 2/4/13 at 4:00 p.m., the resident's blood sugar was 228. The resident received 12 units of insulin and should have received 4 units of insulin. On 2/6/12 at 6:00 a.m., the resident's blood sugar was 240. The resident did not receive any insulin and she should have received 4 units of insulin. On 2/8/13 at 11:30 a.m., the resident's blood sugar was 435. The resident received 12 units of insulin. There was no physician's order for insulin to be given. On 2/12/13 at 6:00 a.m. the resident's blood sugar was 243. The resident received no insulin and she should have received 4 units of insulin. On 2/15/13 at 6:00 a.m., the resident's blood sugar was 469. The resident received 12 units of insulin. There was no order from the physician for any insulin coverage. At 4:00 p.m., the resident's blood sugar was 216. The resident received no insulin and she should have received 4 units of insulin. The resident's blood sugar on 2/16/13 at 6:00 a.m. was 411. The</p>				<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>· The CQI tool titled "Insulin Administration Monitoring" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance with assessment and documentation procedures.</p> <p>· The CQI committee reviews the audits monthly and action plans are developed as the threshold of 95% is not met to ensure continual compliance. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.</p> <p>· The Director of Nursing Services or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: March 24, 2013</p>		

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	<p>resident received 12 units of insulin There was no order from the physician for any insulin coverage. On 2/19/13 at 11:00 a.m., the resident's blood sugar was 470. The resident received 10 units of insulin. There was no order from the physician for any insulin coverage. On 2/20/13 at 6:00 a.m., the resident's blood sugar was 180. The resident did not receive any insulin and she should have received 2 units of insulin</p> <p>Interview with the Director of Nursing on 2/22/13 at 5:30 p.m., indicated a call had been made to the physician to clarify what insulin coverage the resident should receive when her blood sugars were between 401 and 500. There was no other information provided.</p>						